

E-filing

555

COMPLAINT BY A PRISONER UNDER THE CIVIL RIGHTS ACT, 42 U.S.C. § 1983

FILED
MAY 23 PM 2:55

Name PIERCE ARON CHAD H. WILSON
(Last) (First) (Initial)

Prisoner Number J-55222

Institutional Address CALIFORNIA REHABILITATION CENTER/404-34 COW

POST OFFICE BOX #3535, NORCO, CALIFORNIA 92860-0991

UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CV 08

2030

ARON JAMES PIERCE
(Enter the full name of the
plaintiff in this action)

Case No. _____
(To be provided by JF clerk
of court)

(PR)

vs.

MATTHEW MARTIN (CRC WARDEN) et al.

COMPLAINT UNDER THE CIVIL
RIGHTS ACT, 42 U.S.C § 1983

SARV GROVER, M.D. (CRC CMO)

NURSE WEBLY (CRC NURSE)

☒ DEMAND FOR JURY TRIAL
☐ NO JURY TRIAL DEMAND
(check one only)

DOCTOR DO, M.D. (CRC-IV DOCTOR)
(Enter the full name of the
defendant(s) in this action)

All questions on this complaint form must be answered in order
for your action to proceed.

I. Exhaustion of Administrative Remedies

Note: You must exhaust your administrative remedies before
your claim can go forward. The court will dismiss any
unexhausted claims.

ORIGINAL

- A. Place of present confinement CALIFORNIA REHABILITATION CENTER
- B. Is there a grievance procedure in this institution?
YES (☒) NO ()
- C. Did you present the facts in your complaint for review through the grievance procedure? YES (☒) NO ()
- D. If your answer is YES, list the appeal number and the date and result of the appeal at each level of review. If you did not pursue a certain level of appeal, explain why.
1. Informal appeal FIRST LEVEL PARTIALLY GRANTED ON 03-06-08 WHICH IS CRC MEDICAL STAFF'S CLEVER WAY OF DENYING IT.
 2. First formal level FIRST FORMAL LEVEL SINCE IT WAS A CQC ADA 1824 WAS SAME RESPONSE AND DATE AS ABOVE BECAUSE THERE IS NO INFORMAL LEVEL FOR 1824 ADA REQUESTS.
 3. Second formal level ON 03-26-08 SECOND FORMAL LEVEL OF 1824 TO 602 WAS AGAIN PARTIALLY GRANTED, WHICH MEANS DENIED!
 4. Third formal level ON MAY 05, 2008 DIRECTOR IN DENIAL AGAIN STATES AS PRISON MEDICAL STAFF DID "APPEAL PARTIALLY GRANTED"
- E. Is the last level to which you appealed the highest level of appeal available to you? YES (☒) NO ()
- F. If you did not present your claim for review through the grievance procedure, explain why. N/A

II. Parties

Write your name and your present address. Do the same for additional plaintiffs, if any.

- A. AARON JAMES PIERCE J55222/409-34 LOW, CALIFORNIA REHABILITATION CENTER/TJL

ORIGINAL

POST OFFICE BOX #3535, NORCO, CALIFORNIA 92860-0991

Write the full name of each defendant, his or her official position, and his or her place of employment.

B. MATTHEW MARTELL (WARDEN OF CALIF. REHAB. CENTER)

DR. SARV GROVER, M.D., (CRC CHIEF MEDICAL OFFICER)

III. Statement of Claim

State here as briefly as possible the facts of your case. Be sure to describe how each defendant is involved and to include dates, when possible. Do not give any legal arguments or cite any cases or statutes. If you have more than one claim, each claim should be set forth in a separate numbered paragraph.

I SUFFER FROM POST TRAUMATIC ARTHRITIS IN PELVIS (BOTH SIDES)
FROM MOTORCYCLE VERSUS AUTOMOBILE ACCIDENT (SEE ATTACHED HOSPITAL REPORT)
WHERE I BROKE ELEVEN BONES, INCLUDING FRACTURING MY SKULL, WHICH PUT ME IN
A COMA FOR SIX AND A HALF WEEKS AND HAS CAUSED RIGHT BRAIN LOBE DAMAGE (SEE
CATSCAN OF BRAIN WHICH IS ATTACHED) AND I SUFFER FROM HEPATITIS 'C' FACILITY
DOCTOR BUT, M.D. HAS PRESCRIBED MEDICATION WHICH DOES RELIEVE SOME,
BUT NOT ALL OF THE CRONIC PAIN I AM ALWAYS IN, AND SHE ORDERED THAT
I RECEIVE PHYSICAL THERAPY, BUT CRC FACILITY ID MEDICAL NURSES
STATED "I WILL PROBABLY NEVER RECEIVE PHYSICAL THERAPY," DR. DIANA BUT, M.D.
ORDERED ME TO GIVE BLOOD TESTS WHEN I ASKED HER FOR INTERFERON

ORIGINAL

THERAPY WHICH I HAVE BEEN ASKING CACR DOCTORS FOR SINCE 2000, BUT
AT MY LAST VISIT WITH DR. BUT, WHICH JUST TOOK PLACE SHE TOLD ME
THAT SHE WILL NOT BE SEEING ME AGAIN UNTIL LATE IN MAY, 2008
WHICH IS WHEN I WILL ONLY HAVE APPROXIMATELY FORTY (40) DAYS
LEFT TO SERVE UNTIL MY 07-10-08 RELEASE DATE WHICH MEANS
I WILL AGAIN BE DENIED MEDICAL TREATMENT BY CACR PAROLE
LIKE HAPPENED IN REGARD TO THE HERNIA I GOT IN PRISON IN 2001
AND CACR DID NOT HAVE REPAIRED UNTIL 2005, WHEN PAROLE SUPERVISOR
LUCIA GALLAND (PATE) STATED "MY HERNIA WAS A PRISON PROBLEM"
AND IS WHY I FILED U.S. NO. DISTRICT COURT CASE NUMBER: C-03-04934 JF
AGAINST CACR.

IV. Relief

Your complaint cannot go forward unless you request specific relief. State briefly exactly what you want the court to do for you. Make no legal arguments; cite no cases or statutes.

ONE MILLION DOLLARS, AND FOR CACR TO PROVIDE ME WITH PHYSICAL
THERAPY REGARDING ARTHRITIS IN MY HIPS AND INTERFERON TREAT-
MENT FOR HEPATITIS IMMEDIATELY, AND FOR THIS CASE TO REMAIN
COMPLETELY SEPARATE FROM CASE NUMBER: C-03-04934 JF. FOR
CDC/RCUSTODY AND/OR PAROLE OFFICIALS TO PROVIDE ME WITH MEDICAL ATTENTION
I NEED.

DATED: 05-09-08

Baron James Punter
 (Plaintiff's signature)

VERIFICATION
(optional)

I am the plaintiff in the above-entitled action. I have read the foregoing complaint and know the contents thereof. The same is true of my own knowledge, except as to those matters which are therein alleged on information and belief, and as to those matters, I believe it to be true. I declare under penalty of perjury that the foregoing is true and correct.

Dated: 05-09-08

Baron James L...
(Plaintiff's signature)

JURY TRIAL DEMAND
(optional)

I demand a jury trial for all claims for which a jury trial is allowed.

YES (☒) NO (☐) (check one only)

Dated: 05-09-08

Baron James L...
(Plaintiff's signature)

ORIGINAL

1 AARON JAMES PIERCE, J-55222/409-34 LOW
 2 CALIFORNIA REHABILITATION CENTER - NORCO
 POST OFFICE BOX #3535
 NORCO, CALIFORNIA 92860-0991

3
 4 UNITED STATE DISTRICT COURT

5 NORTHERN DISTRICT OF CALIFORNIA

6
 7
 8 AARON JAMES PIERCE

9 Plaintiff,

10 vs.

CASE NUMBER: C-03-04934 JF

11 EDWARD S. ALAMEIDA JR, et al.

12 Defendant(s).

DECLARATION OF PLAINTIFF IN
 REGARD TO ATTACHED RESPONSE
 FROM DIRECTOR OF CORRECTIONS
 FOR AN EMERGENCY COCR 602

13
 14
 15 I, AARON JAMES PIERCE, PLAINTIFF IN PRO-SE, DECLARE UNDER THE
 16 PENALTY OF PERJURY THAT THE FOLLOWING STATEMENTS ARE ALL TRUE AND
 CORRECT.

RE:

- 17 (1) REGARDING ARGUMENT I AM IN CONSTANT PAIN AND DR. DIANA BUI, M.D.
 18 ORDERED I RECEIVE PHYSICAL THERAPY FOR PELVIS WHERE I SUFFER
 FROM ARTHRITIS AND A BLOOD TEST REGARDING MY REQUEST I MADE
 19 FOR INTERFERON AND NURSES STATE MEDICAL DEPT. IS TOO BUSY TO
 PROVIDE ME WITH PHYSICAL THERAPY REGARDING MY PELVIS, AND
 I DID GIVE A BLOOD TEST REGARDING MY LIVER BUT NO INTERFERON HAS
 20 BEEN PRESCRIBED TO ME AND I DOUBT IF ANY WILL BY COCR DOCTOR'S
 (2) DR. DIANA BUI, M.D. ORDERED I RECEIVE PHYSICAL THERAPY BUT
 I HAVE BEEN TOLD BY NURSES HERE AT CRC-IV THAT IT WILL NOT
 21 HAPPEN AND THAT IS THE PHYSICAL THERAPY I NEED.
- (3) THE REASON I DISAGREE WITH MEDICATION AND TREATMENTS IS MEDICATION
 IS NOT STRONG ENOUGH AND I AM NOT RECEIVING TREATMENT I NEED.
- (4) REGARDING COCR REJECTING TO FILE MY ADA 1824 I AM SIMPLY ASKING FOR
 22 PHYSICAL THERAPY AND INTERFERON THAT OTHER COCR INMATES GET.
 SO IT WAS ILLEGAL FOR COCR TO REJECT MY ADA CLAIMS IN THAT 1824
 23 ADA REQUEST BECAUSE I AM A COCR ADA INMATE.
- (5) I HAVE HAD HEPATITIS 'C' SINCE 1989 COCR KNOWS THAT BUT COCR STAFF
 24 NEVER DO MORE THAN TAKE BLOOD TEST WHEN I AM TOLD BY OUTSIDE
 OF PRISON DOCTOR TO ASK FOR A LIVER BIOPSY AND I HAVE BUT I HAVE NEVER
 25 RECEIVED ONE
- (6) I MAY HAVE BEEN REFERRED FOR PT REGARDING HCV TREATMENTS BUT I'VE
 NOT RECEIVED PT FOR ANYTHING.
- (7) I DO NOT AGREE WITH COCR/CRC DOCTORS AND NURSES BECAUSE THEY ARE
 26 NOT DOING ANYTHING AT ALL FOR MY MEDICAL NEEDS.

27 I DECLARE UNDER PENALTY OF PERJURY THAT ALL OF THE FOREGOING IS
 TRUE AND CORRECT. EXECUTED ON 05-14-08 IN NORCO, CALIFORNIA.

28 05-14-08
 (DATE)

Aaron James Pierce
 AARON JAMES PIERCE
 PLAINTIFF AND DECLARANT

COPY

EXHIBIT

STATE OF CALIFORNIA
DEPARTMENT OF CORRECTIONS AND REHABILITATION
INMATE APPEALS BRANCH
P. O. BOX 942883
SACRAMENTO, CA 94283-0001

DIRECTOR'S LEVEL APPEAL DECISION

Date: **MAY 05 2008**

In re: Aaron Pierce, J55222
California Rehabilitation Center
P.O. Box 1841
Norco, CA 92860-0991

IAB Case No.: 0723689

Local Log No.: CRC-08-00156

This matter was reviewed on behalf of the Director of the California Department of Corrections and Rehabilitation (CDCR) by Appeals Examiner B. Sullivan, Staff Services Manager I. All submitted documentation and supporting arguments of the parties have been considered.

① **I APPELLANT'S ARGUMENT:** It is the appellant's position that he is in severe pain and his pain medications are not working. He also states he needs Physical Therapy (PT). He asks for pain medication that works, PT regarding his arthritis, and proper treatment for his Hepatitis "C" Virus (HCV).

② **II SECOND LEVEL'S DECISION:** The reviewer found that on February 2, 2008, the appellant was seen by Dr. Bui. His medications were reviewed and adjusted. On Marcy 18, 2008, Dr. Bui discussed the risks and benefits of the appellant's current medications including the appellant's request for Interferon Therapy. It was determined that further monitoring is warranted before therapy will be considered. Dr. Bui completed a referral for PT. The appellant's request for Interferon is pending based upon further evaluation. The appeal is granted in part at the Second Level of Review.

III DIRECTOR'S LEVEL DECISION: Appeal is denied.

③ **A. FINDINGS:** This appeal at the Director's Level of Review (DLR) has been reclassified as a medical appeal. The appellant is requesting pain medications, PT, and HCV treatments. He disagrees with his current treatment. ④ An Americans with Disabilities Act (ADA) appeal must involve a request for access or participation in a program, service, or activity where the inmate claims that access or participation is impaired or limited due to a disability; thus the request for reasonable modification or accommodation. These appeal issues do not meet the requirements to be filed as an ADA appeal.

⑤ At the DLR the appellant states that he has not received PT yet and he has had HCV for over two decades with no Interferon treatments. He believes the California Rehabilitation Center (CRC) is completely ignoring his medical needs.

⑥ The appellant has been referred for PT and for additional monitoring regarding his HCV treatments. His medications have been explained and discussed with him. From all information included in this appeal, it is evident the appellant's medical needs are being addressed at CRC. While the appellant might disagree with the medical opinions of the doctors and specialists at CRC who have examined him and reviewed his Unit Health Record, he must realize that the California Code of Regulations, Title 15, Section (CCR) 3354 establishes that only qualified medical staff shall be permitted to diagnose illness and prescribe medication and medical treatment for inmates. ⑦ After considering the evidence and arguments herein, it has been determined that staff acted appropriately on the appellant's request.

B. BASIS FOR THE DECISION:
CCR: 3350, 3354

C. ORDER: No changes or modifications are required by the Institution.

EXHIBIT

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**INMATE/PAROLEE
APPEAL FORM**
CDC 802 (12/87)

Location: Institution/Parole Region

Log No.

Category

1. CRC
2. _____

1. M08-C156
2. _____

18-ADA
(9)

You may appeal any policy, action or decision which has a significant adverse affect upon you. With the exception of Serious CDC 115s, classification committee actions, and classification and staff representative decisions, you must first informally seek relief through discussion with the appropriate staff member, who will sign your form and state what action was taken. If you are not then satisfied, you may send your appeal with all the supporting documents and not more than one additional page of comments to the Appeals Coordinator within 15 days of the action taken. No reprisals will be taken for using the appeals procedure responsibly.

NAME	NUMBER	ASSIGNMENT	UNIT/ROOM NUMBER
PIERCE AARON	J55222	3d WATCH OORM 409 PORTER	409-39-L

A. Describe Problem: PARTIALLY GRANTING MY ADA 1874 IN BASIC ENGLISH MEANS "DENYING IT" BECAUSE (#1) EVEN THOUGH THE PAIN MEDICATION I AM RECEIVING WORKS TO PARTIALLY RELIEVE PAIN IN MY PELVIS I STILL NEED AND AM ENTITLED TO (A) PHYSICAL THERAPY REGARDING ARTHRITIS IN PELVIS AND (B) INTERFERON FOR MY HEPATITIS AND I GET THE IMPRESSION FROM CDCR DOCTOR'S THAT "I MUST BE CLOSE TO DEATH BEFORE CDCR WILL PROVIDE ME WITH INTERFERON" AND THAT IS A DIRECT VIOLATION OF CONSTITUTIONAL & STATE LAWS SO IM CONTINUING THIS APPEAL
If you need more space, attach one additional sheet.

B. Action Requested: THAT I RECEIVE PHYSICAL THERAPY AND INTERFERON IMMEDIATELY. (SEE SECOND FORMAL LEVEL WHICH STATES THE SAME REQUEST I JUST MADE HERE.

Inmate/Parolee Signature: Aaron James Pierce

Date Submitted: 03-08-08

C. INFORMAL LEVEL (Date Received: _____)

Staff Response: _____

RECEIVED
 APR - 7 2008
 INMATE APPEALS BRANCH

Staff Signature: _____ Date Returned to Inmate: _____

D. FORMAL LEVEL

If you are dissatisfied, explain below, attach supporting documents (Completed CDC 115, Investigator's Report, Classification chrono, CDC 128, etc.) and submit to the Institution/Parole Region Appeals Coordinator for processing within 15 days of receipt of response.

Signature: _____

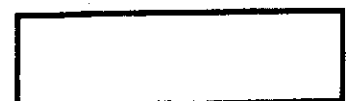
Date Submitted: _____

Note: Property/Funds appeals must be accompanied by a completed Board of Control form BC-1E, Inmate Claim

CDC Appeal Number: _____

COPY

EXHIBIT



First Level ☐ Granted ☐ P. Granted ☐ Denied ☐ Other

E. REVIEWER'S ACTION (Complete within 15 working days): Date assigned: _____

Interviewed by: _____

Due Date: _____

Staff Signature: _____

Division Head Approved: _____

Signature: _____

Title: _____

Date Completed: _____

Returned: _____

Date to Inmate: _____

F. If dissatisfied, explain reasons for requesting a Second-Level Review, and submit to Institution or Parole Region Appeals Coordinator within 15 days of receipt of response.

AS I STATED ABOVE I WANT (#1) INTERFERON AND (#2) PHYSICAL THERAPY IMMEDIATELY FOR ARTHRITIS IN MY PELVIS PLEASE

Signature: _____

Second Level ☐ Granted ☒ P. Granted ☐ Denied ☐ Other

Date Submitted: 03-08-08

G. REVIEWER'S ACTION (Complete within 10 working days): Date assigned: 3.13.08

☒ See Attached Letter

Due Date: 3.27.08

Signature: _____

Warden/Superintendent Signature: _____

Date Completed: 3-20-08

Date Returned to Inmate: 3-27-08

H. If dissatisfied, add date or reasons for requesting a Director's Level Review, and submit by mail to the third level within 15 days of receipt of response.

- ① DR. DIANA BUI, M.D. ORDERED "PHYSICAL THERAPY RE: ARTHRITIS IN MY PELVIS" AND NURSE SAID "MEDICAL IS SO BUSY IT WILL BE MONTHS BEFORE I BEGIN THERAPY"
- ② I HAVE NOT BEEN SEEN & PRESCRIBED INTERFERON & IVE HAD HEPATITIS 'C' FOR OVER TWO DECADES, SO CRS IS COMPLETELY IGNORING MY MEDICAL NEEDS
- ③ I SUBMITTED EMERGENCY SICKCALL REQUEST FOR FILLING IN HUGE CAVITY & DENTIST SAID "HE WILL GIVE ME FILLING" BUT HE SAID "HE DOES NOT KNOW WHEN"

Signature: Aaron James Turner

Date Submitted: 04-01-08

For the Director's Review, submit all documents to: Director of Corrections
P.O. Box 942883
Sacramento, CA 94283-0001
Attn: Chief, Inmate Appeals

DIRECTOR'S ACTION: ☐ Granted ☐ P. Granted ☒ Denied ☐ Other

☒ See Attached Letter

CDC 602 (12/87)

Date: MAY 05 2008

EXHIBIT

COPY

STATE OF CALIFORNIA

DEPARTMENT OF CORRECTIONS

**REASONABLE MODIFICATION OR
ACCOMMODATION REQUEST**
CDC 1824 (1/95)

INSTITUTION/PAROLE REGION:	LOG NUMBER:	CATEGORY:
	CRC-1700-0156	18 ADA

FEB 1978: 2003 FORM IS TO BE USED ONLY BY INMATES/PAROLEES WITH DISABILITIES

In processing this request, it will be verified that the inmate/parolee has a disability which is covered under the Americans With Disabilities Act.

CRC APPEALS OFFICE

INMATE/PAROLEE'S NAME (PRINT)	CDC NUMBER	ASSIGNMENT	HOURS/WATCH	HOUSING
PIERCE AARON	J55222	ADA/A-1-A	N/A	IX #409-342

In accordance with the provisions of the Americans With Disabilities Act (ADA), no qualified individuals with a disability shall, on the basis of disability, be excluded from participation in, or be denied the benefits of the services, activities, or programs of a public entity, or be subjected to discrimination.

You may use this form to request specific reasonable modification or accommodation which, if granted, would enable you to participate in a service, activity or program offered by the Department/institution/facility, for which you are otherwise qualified/eligible to participate.

Submit this completed form to the institution or facility's Appeals Coordinator's Office. A decision will be rendered within 15 working days of receipt at the Appeals Coordinator's Office and the completed form will be returned to you.

If you do not agree with the decision on this form, you may pursue further review. The decision rendered on this form constitutes a decision at the FIRST LEVEL of review.

To proceed to SECOND LEVEL, attach this form to an Inmate/Parolee Appeal Form (CDC 602) and complete section "F" of the appeal form.

Submit the appeal with attachment to the Appeals Coordinator's Office within 15 days of your receipt of the decision rendered on this request form.

If you are not satisfied with the SECOND LEVEL review decision, you may request THIRD LEVEL review as instructed on the CDC 602.

MODIFICATION OR ACCOMMODATION REQUESTED

DESCRIPTION OF DISABILITY:

ADA MOBILITY IMPAIRED INMATE WITH ⁽¹⁾ POST TRAUMATIC
ARTHRITIS IN PELVIS ⁽²⁾ HEPATITIS ⁽³⁾ ARTHRITIS IN RIGHT HAND

WHAT VERIFICATION DO YOU HAVE OF YOUR DISABILITY?

PROOF OF THE ABOVE DISABILITIES IS LISTED IN MY CDC
MEDICAL FILE.

DESCRIBE THE PROBLEM:

I AM IN SEVERE PAIN IN PELVIS AND THE PAIN
MEDICATION I WAS TAKING AND QUIT IS NOT WORKING AND FAMILY
MEMBER WHO IS A REGISTERED NURSE TOLD ME "IT IS BAD FOR ME TO
TAKE MEDICATION (LIVER) THAT IS NOT WORKING WHICH IS WHY I SIGNED
REFUSAL FORM, AND NOW I NEED ⁽¹⁾ NEW MEDICATION ⁽²⁾ REHABILITATION
TREATMENT PLAN FOR MY ABOVE PROBLEMS.

WHAT SPECIFIC MODIFICATION OR ACCOMMODATION IS REQUESTED?

^(#1) PAIN MEDICATION THAT
WORKS ^(#2) REHABILITATION PLAN REGARDING ARTHRITIS ^(#3) INTER-
FERON FOR HEPATITIS 'C' IF LIVER PANEL JUST TELL ME I
NEED THAT MEDICATION.

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APR - 7 2008
INMATE APPEALS BRANCH

RECEIVED

Aaron James Pierce
INMATE/PAROLEE'S SIGNATURE

02-11-08 MAR 13 2008
DATE SIGNED

EXHIBIT COPY

CDC APPEALS OFFICE

REASONABLE MODIFICATION OR ACCOMMODATION REQUEST
CDC 1824 (1/95)
REVIEWER'S ACTION
TYPE OF ADA ISSUE
DATE ASSIGNED TO REVIEWER:
DATE DUE:
☐ PROGRAM, SERVICE, OR ACTIVITY ACCESS (Not requiring structural modification)

☐ Auxiliary Aid or Device Requested

☒ Other AIN Medications, Rehabilitation Plan for Arthritis, Interferon for Hep C
☐ PHYSICAL ACCESS (requiring structural modification)

DISCUSSION OF FINDINGS:

Mr. Pierce you were seen by your Unit Physician on 2/20/08 when your health care concerns were addressed. You currently have medications prescribed for pain as you requested. During our interview you stated that current medications have helped and you were satisfied with them. You currently have a pending and confirmed appointment with your Unit Physician to discuss if physical therapy is warranted for your arthritis. At this time you are receiving the treatment your Unit Physician has deemed appropriate for hepatitis. However you have a pending and confirmed appointment to discuss Interferon.

DATE INMATE/PAROLEE WAS INTERVIEWED
PERSON WHO CONDUCTED INTERVIEW
DISPOSITION
☐
GRANTED
☐
DENIED
☒
PARTIALLY GRANTED
BASIS OF DECISION:

- * Currently receiving pain medications that patient stated he is satisfied with.
- * Currently has pending and confirmed appointment to determine if physical therapy is needed.
- * Patient is currently receiving treatment physician deems necessary for hepatitis however currently has pending and confirmed appointment to discuss Interferon.

NOTE: If disposition is based upon information provided by other staff or other resources, specify the resource and the information provided. If the request is granted, specify the process by which the modification or accommodation will be provided, with time frames if appropriate.

DISPOSITION RENDERED BY (NAME)
TITLE
INSTITUTION/FACILITY
APPROVAL
ASSOCIATE WARDEN'S SIGNATURE
DATE SIGNED
DATE RETURNED TO INMATE/PAROLEE

DEPARTMENT OF CORRECTIONS

STATE OF CALIFORNIA

DR. TABODOB. 11-26-64HOUSING HOSPHOSPITAL OF
CALIFORNIA INSTITUTION FOR MEN
CHINO, CALIFORNIA

Radiology Report

NAME PIERCE, AARON NO. N-57816 DATE 9-23-94X-RAY OF CT SCAN OF HEAD

History _____

NON-CONTRAST ^{CT} SCAN OF THE HEAD: Utilizing a Siemens DRILL Ct scanner, scans were obtained through the head without contrast, for a total of 12 axial images with bone windows also presented for dictation.

FINDINGS: No fractures seen. I see no midline shift. I see no subdural or epidural collection of fluid. There is prominence to the temporal horn of the lateral ventricle on the right. This could be due to some atrophy secondary to previous trauma. I see no acute changes.

IMPRESSION: I see no active disease.

JPW: gk

DET: 9-26-94

J. P. Warren, M.D.

EXHIBIT

NAME PIERCE, AARON NO. N-57816 DATE 9-12-94X-RAY OF CHESTHistory PSYCH D/O

CHEST: Negative

EXHIBIT

JPW: jl

DET: 9-13-94

DET: 9-14-94

J. P. Warren, M.D.

JAMES P. WARREN, M.D.

KERN RADIOLOGY MEDICAL GROUP, INC.
2301 Bahamas Drive
Bakersfield, CA 93309
Telephone 324-7000
Fax 322-6911

WASCO STATE PRISON

PATIENT: PIERCE
DOA:

DOB:
HOUSING UNIT: C-


CDC# N-57816

BOTH HIPS: 3/22/95

INDICATION: Old accident.

AP and frogleg views of both hips were obtained. The hip joints are well maintained. No fracture or dislocation is identified. There is diastasis of the symphysis pubis with several bone fragments in the soft tissues. There are exostoses involving the anterior superior iliac spine on the right and the left iliac crest. These findings are presumably post traumatic in origin.

IMPRESSION: Normal examination of both hips. Post traumatic residuals involving the symphysis pubis and both innominate bones as noted.


JERRY ROSEN, M.D.
Referring Physician: Sulman

D3/22/95 T3/23/95/lmj

COPY

EXHIBIT

Proof of Service by Mail (CCP § 1013(a) & 2015.5; 28 USC 1746)

AARON JAMES PIERCE V. MATTHEW MARTEL, et al. CASE:

SUPPLIED BY CLERK

I declare that: I, AARON JAMES PIERCE J55222/409-3460W

I am a resident of the County of RIVERSIDE, California. I am
 over the age of eighteen years. My residence address is:

CALIFORNIA REHABILITATION CENTER-NORCO, P.O. BOX #3535, NORCO,CALIFORNIA 92860-0991

On MAY 18, 2008 I served the attached ① ORIGINAL AND TWO PHOTOCOPIES OF COMPLAINT UNDER THE CIVIL RIGHTS ACT, U.S.C. § 1983, ② ONE PHOTOCOPY OF DECLARATION OF PLAINTIFF IN REGARD TO ATTACHED RESPONSE FROM DIRECTOR OF CORRECTIONS FOR AN EMERGENCY COC 602 (EXHIBIT) ③ CDC 1824 AND COC 602 (EXHIBITS), ④ PHOTOCOPY OF HEAD (EXHIBIT) ⑤ X-RAY OF HIPS (EXHIBIT) ⑥ THIS PROOF OF SERVICE AND REQUEST FOR CLERK OF ABOVE ENTITLED COURT TO RETURN A CONFORMED COPY OF THIS MAIL on the PARTIES LISTED HEREINAFTER in said case, by placing a true copy thereof enclosed

in a sealed envelope with postage thereon fully paid in the United States mail at CALIFORNIAREHABILITATION CENTER AT FIFTH ST. AND WESTERN AVE., NORCO, CAL. 92860

addressed as follows

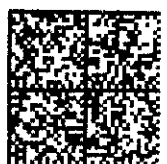
CLERK	OF	THE	COURT
UNITED STATES DISTRICT COURT			
NORTHERN DISTRICT OF CALIFORNIA			
450 GOLDEN GATE AVENUE			
POST OFFICE BOX #36060			
SAN FRANCISCO, CALIFORNIA			94102

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on (date) MAY 18, 2008, at CRC IN THE COUNTY OF RIVERSIDE, California.

Type or print name: AARON JAMES PIERCESignature: Aaron James Pierce
PLAINTIFF AND DECLARANT

ARON JAMES NIERCE JT-55222-409/3460w
CALIFORNIA REHABILITATION CENTER — NORCO
P.O. #3535
NORCO, BOX
CALIFORNIA 92860-0991

MAIL GENERATED FROM
CA REHAB CENTER
CRC STATE PRISON



UNITED STATES POSTAGE
02 1M
0004222768
MAILED FROM ZIP

RECEIVED
MAY 21 11:35
SIGNED: J. STEVENS
CLERK, U.S. DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

Prose

CLERK OF THE COURT
UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
450 GOLDEN GATE AVENUE
POST OFFICE BOX 36060
SAN FRANCISCO, CALIFORNIA 94102